Your

Group Insurance

Plan

IMPORTANT

When you receive your "Certificate of Coverage - Form P" confirming that you are insured, peel the tape slowly from the back of it. Then attach in this space.

This certificate of insurance is not an insurance policy and does not amend, extend or alter the coverage afforded by the policy/policies listed herein. Notwithstanding any requirement, term, or condition of any contract or other document with respect to which this certificate of insurance may be issued or may pertain, the insurance afforded by the policy/policies described herein is subject to all the terms, exclusions and conditions of such policies.

SCHEDULE OF BENEFITS

EMPLOYEE

LIFE (Based on Annual Earnings)
Less than $20,000 .....(1)
$20,000 and Over .....(2)

ACCIDENTAL DEATH, DISMEMBERMENT
AND LOSS OF SIGHT - (Full Amount of Insurance)
Same as Life Benefits

EMPLOYEE and DEPENDENTS

X-RAY AND LABORATORY	$ 100
ADDITIONAL ACCIDENT	$ 500
DENTAL	$ 1,500
MAJOR MEDICAL	(3) $1,000,000
HOME HEALTH CARE Maximum Payment per Visit	$ 40

(1) 100% of annual earnings with a maximum of $150,000.

(2) 150% of annual earnings with a maximum of $150,000.

(3) $25,000 maximum with respect to charges in connection with mental illness(es) or functional nervous disorder(s) of any type or cause.

Your Life and Accidental Death, Dismemberment and Loss of Sight benefits reduce 50% at age 70.

Changes in amounts of benefits due to a change in earnings will be made immediately on the date a change in earnings becomes effective.

Life and Accidental Death, Dismemberment and Loss of Sight benefits cover you on and off the job. All other benefits cover you only for accidents and sicknesses originating off the job. No benefits are provided for charges which you are not legally obligated to pay, such as for U. S. Government Hospital confinement and services, nor for claims to which you or your dependents are entitled to Worker's Compensation benefits.

NOTE: "Illness" or "Sickness" means a bodily disorder or disease, pregnancy, mental infirmity or bodily injury. All bodily injuries sustained by an individual in a single accident, or all illnesses or sicknesses which are due to the same or related cause or causes, will be considered one illness or sickness.

Pregnancy benefits are payable on the same basis as any other illness.

DESCRIPTION OF BENEFITS

LIFE, ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT INSURANCE

LIFE INSURANCE

Life Insurance benefits are payable as a result of death from any cause.

You may change your beneficiary without the beneficiary's consent by giving written notice to The Lincoln National Life Insurance Company, (hereinafter also called The Lincoln) through your Employer. The change will become effective as of the date you signed the notice.

An absolute assignment of all the incidents of ownership of group life insurance under the policy, as evidenced by this certificate will be permitted. Collateral assignments, by whatever name called, will not be permitted.

Conversion

If your life insurance terminates either because of termination of employment, transfer to a class of employees not eligible under the policy, or as a result of disability, you may convert your insurance to any form of individual policy of life insurance (without double indemnity or disability riders) then customarily issued by The Lincoln except a policy of term insurance.

If the Master Policy terminates or is amended so as to terminate your insurance, and you have been insured under the policy (or any Lincoln policy it replaced) for at least 5 years, you may convert your insurance for an amount not in excess of the smaller of (a) $2,000 or (b) the amount of your terminated insurance less any amount of life insurance for which you may be eligible under any Group policy which replaces it within 31 days.

You have 91 days to make application for conversion and pay the required premium following termination of your insurance. However, if you are given written notice of your right to convert, you have no more than 31 days from the date of termination of insurance, or until 25 days after you are given such notice, whichever is the later date.

The premium will be at your attained age and class of risk. No evidence of insurability is required. If you should die during the first 31 days of this period, the amount of insurance which you are entitled to convert will be paid to your beneficiary, even if you have not applied for conversion.

If your life insurance is paid under the group policy, payment will not be made under the converted policy and premiums paid for the converted policy will be refunded.

Disability Benefits

If, while you are insured, you become totally disabled (as defined in the Master Policy) prior to attaining age 60, and you die while totally

disabled and within one year from the date premium payment terminated, payment of your life insurance will be made.

Also, if you furnish proof within 12 months after the date premium payment terminated, that you are totally and permanently disabled and became so disabled while insured, before attaining age 60, your insurance will be extended without premium for a period of one year from the date proof is submitted. Year to year extensions for further periods of one year each will be made if further proof of continuance of total and permanent disability is furnished within 3 months prior to each anniversary of the date of the original proof of such disability. All insurance under this provision terminates upon attainment of age 65.

Your employer may continue to make premium payment for your life insurance benefits for up to 12 months while you are unable to work because of disability.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT INSURANCE

Full amount is payable for losses occurring within 90 days of an accident and as the result of accidental bodily injury and independent of all other causes for loss of: (1) life (in addition to the amount of Life Insurance), (2) both hands, (3) both feet, (4) sight of both eyes, (5) one hand and one foot, (6) one hand and the sight of one eye, (7) one foot and the sight of one eye. One-half amount is payable for loss of one hand, one foot, or sight of one eye.

No payment is made for losses occurring as a result of self-destruction or attempted self-destruction or self-inflicted injury, insurrection, war, participating in a riot, committing an assault or felony, disease of the body, mental infirmity, medical or surgical treatment or diagnosis therefor, ptomaines, bacterial infection, taking of poison, asphyxiation from or inhaling of gas.

No more than the full amount shall be paid for all losses resulting from any one accident.

MEDICAL EXPENSE INSURANCE

X-RAY AND LABORATORY EXPENSE INSURANCE

Diagnostic X-Ray and Laboratory Expense benefits provide payment for x-ray and laboratory examination. Benefits are payable up to the maximum shown in the Schedule of Benefits for all injuries resulting from any one accident or for all sicknesses during any calendar year.

Benefits are not payable for pre-marital examinations, x-ray therapy, treatment on or to the teeth or gums, eye refractions, fitting of glasses, expenses incurred while confined in a hospital or to the extent of any payment for a charge under any other benefits of the plan.

ADDITIONAL ACCIDENT EXPENSE INSURANCE

Additional Accident Expense benefits provide payment for charges incurred as a result of and within three months of an accidental bodily injury up to the maximum aggregate payment shown in the Schedule of Benefits for each injury in excess of the amounts, if any, provided by the X-Ray and Laboratory Expense Insurance of this plan. Benefits are payable for medical or surgical treatment or supplies, confinement in a legally constituted hospital, laboratory and x-ray examinations or services of a registered nurse.

Benefits are not payable for or on account of eye refractions.

COMPREHENSIVE DENTAL EXPENSE INSURANCE

Dental Expense Benefits are payable up to the maximum shown in the Schedule of Benefits. This benefit is payable in excess of a deductible of $25. The maximum benefit applies each calendar year to you and to each of your dependents.

The expenses must be incurred for dental procedures necessary to the care and treatment of the patient and performed by or under the direct supervision of a legally qualified dentist.

The deductible applies each calendar year to you and to each of your dependents. The deductible is applied to the expenses for the year before any Dental Expense benefits are payable for that year. Furthermore, when any part of a year's deductible is applied against eligible charges arising during the last three months of that calendar year, the following year's deductible will be reduced by the amount so applied.

Dental Expense benefits provide payment of 80% of eligible dental charges, with the exception of charges for inlays, gold fillings, crowns, fixed bridgework and precision attachments for dentures and for orthodontia for which payment is 50%.

100% of the Regular and Customary charge will be paid (and no deductible will apply) for the following specifically listed procedures:

(a) Prophylaxis treatment, including scaling and polishing, not to exceed two such procedures per insured individual in any calendar year;

(b) Four Bite Wing X-rays per individual per calendar year;
(c) One full mouth X-ray per individual during any one period of five calendar years;
(d) One full mouth fluoride treatment per individual per calendar year;
(e) Space maintainers for deciduous teeth.
(f) Two dental examinations per individual, per calendar year.

For orthodontia, payment is made up to a lifetime maximum payment per person of $1,000.

The overall maximum payment for all dental expenses (excluding orthodontia) per calendar year, per person is $1,500.

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure. If a procedure is not completed in one day, the day upon which the procedure is completed is deemed to be the incurred day for any charges in connection with such procedure.

In the event that more than one dentist furnishes services or materials for one dental procedure, Lincoln National shall be liable for not more than its liability had one dentist furnished the services or materials.

No payment shall be made under this insurance provision for dental benefits on account of any procedure with respect to which payment is made under any of the other insurance provisions of the policy except to the extent, if any, that the amount provided in this provision of dental benefits exceeds the total amount payable on account of such procedure in all such other provisions.

-THE FOLLOWING DENTAL CHARGES (IF NECESSARY, REASONABLE AND CUSTOMARY) ARE COVERED-

Charges for any accidental bodily injury: (a) which does not arise out of or in the course of any employment by the Employer and (b) for which he is not entitled to benefits under any Worker's Compensation law;

Charges for any sickness not entitling him to benefits under any Worker's Compensation or Occupational Disease law;

Charges which are necessary to the care and treatment of such accidental bodily injury or such sickness and are incurred on the recommendation of and performed by or under the direct supervision of a legally qualified dentist;

Charges which are not in excess of the reasonable and customary charges for the procedure performed or the materials furnished, which excess, if any, shall not be considered as eligible dental charges under the policy, nor counted as part of the deductible amount hereunder;

Charges which are incurred for dental services, supplies and x-ray examinations;

Charges which are not excluded dental charges and are not otherwise excluded from coverage by the terms hereof.

-THE FOLLOWING DENTAL CHARGES ARE NOT COVERED-

-All Charges Not Specifically Listed As Covered Charges And In Addition-

Charges for services or materials for which the individual is not in the absence of this insurance, legally required to pay;

Charges for services or materials received from a dental or medical department maintained by an employer, a mutual benefit association, a labor union, or a health and welfare fund, or for services or materials furnished by or at the direction of the United States Government or any state, province, or other political subdivision, unless the insured individuals would be required to pay such charges in the absence of insurance;

Charges for services or materials for cosmetic purposes, except charges for cosmetic dental procedures incurred while insured hereunder as a result of and within 24 months after an accident suffered while insured hereunder for Dental Expense Benefits;

Charges for facings on crowns, or pontics, posterior to the second bicuspid;

Charges due to war or any act of war, whether declared or undeclared;

Charges for any portion of a dental procedure performed before the effective date of or after the termination of the individual's insurance for Dental Expense Benefits, except eligible dental charges incurred by an individual for dental care furnished within 30 days after termination of his insurance for Dental Expense Benefits hereunder shall be considered eligible for payment if:

(a) the service involves an appliance, or modification of an appliance for which the impression was taken prior to the termination of the individual coverage; or

(b) the service involves a crown, bridge or gold restoration for which the tooth was prepared prior to the termination of individual coverage; or

(c) the service involves root canal therapy for which the pulp chamber was opened prior to the termination of individual coverage; and

(d) the procedure is completed within 30 days after termination of individual coverage and the individual is not otherwise entitled to payment under any other like dental coverage of any type or source.

Charges for periodic oral examinations and/or prophylaxis performed which are in excess of two such same procedures in any calendar year;

Charges for partial or full removable dentures or fixed bridgework, or for the addition of one or more teeth thereto, or for a crown or gold restoration if involving a replacement or modification of a denture, bridgework, crown or gold restoration which was installed during the five years immediately preceding such extraction, replacement or modification;

Charges for partial or full removable dentures or fixed bridgework if involving replacement of one or more natural teeth extracted prior to the individual's becoming insured under the Policy unless the denture

or fixed bridgework also includes replacement of a natural tooth which is extracted while the individual is insured hereunder and was not an abutment to a partial denture or fixed bridge installed within the five years immediately preceding such extraction or modification;

Charges for adjustment to or relining of partial or full removable dentures for which like service was rendered within the two years immediately preceding such adjustment or relining;

Charges for service to an insured which involves: an appliance, or modification of an appliance for which the impression was made before the individual became insured hereunder; or a crown, bridge or gold restoration for which a tooth was prepared before the individual became insured hereunder; or root canal therapy for which the pulp chamber was opened before the individual became insured hereunder;

Charges which are in excess of a payment of $100 in the aggregate for any service(s) or material(s) provided during the first 24-month period following the effective date of coverage for Dental Expense Benefits if the individual was not enrolled for such benefits within the 31-day period immediately following the first day of his eligibility for Dental Expense Benefits hereunder unless such charges are incurred as a direct result of an accident occurring while insured;

Charges for replacement of lost or stolen appliances, dentures or bridgework;

Charges for dental appointments which are not kept;

Charges for any service or material not furnished by a dentist except a service performed by a licensed dental hygienist under the supervision of a dentist or an x-ray ordered by a dentist.

Pre-Determination of Benefits

Recognizing that many dental problems can be solved in more than one way, the insurance company will pay an amount equal to that applicable for that generally accepted treatment method which, in its sole judgment, will provide adequate dental care at the lowest cost to the insured. In determining its liability the insurance company will be guided by nationally established standards of the dental profession.

Those persons contemplating dental work are strongly urged to submit, in advance, a resume of the treatment plan being contemplated. If this is done, the insurance company will determine the benefits available and advise the patient and/or the dentist of the benefits available before treatment commences.

If pre-determination of benefits is not requested, the insurance company retains the right to pay the claim on the basis of the amount of benefits which would have been paid had pre-determination been requested.

Pre-determination is encouraged, particularly if the course of treatment is expected to involve total dental charges of $200 or more.

MAJOR MEDICAL EXPENSE INSURANCE

Major Medical Expense benefits provide payment of eligible charges up to the maximum shown in the Schedule of Benefits. Major Medical pays the first $5,000 of covered hospital charges. It pays 80% (see full payment feature) of all other covered hospital charges and surgical charges and it also pays 80% of all other covered charges in excess of a deductible of $100 plus the amount payable under X-Ray and Laboratory Expense Insurance and Additional Accident Expense Insurance. There is no deductible in connection with (1) charges made by a hospital, (2) hospital type charges at the time of and in connection with a surgical operation wherever performed and (3) fees of physicians for surgical operations.

The deductible applies to the eligible charges of each calendar year, but it applies only once for you, and only once for each dependent, in any calendar year regardless of the number of illnesses. However, if three or more members of a family have satisfied the deductible during the same calendar year, no further deductible applies to any member of that family in connection with charges incurred during the remainder of that calendar year. Furthermore, when any part of a year's deductible is applied against eligible charges arising during the last three months of that calendar year, the following year's deductible will be reduced by the amount so applied.

Full Payment

After an insured person has incurred $2,000 of covered charges or the insured members of a family have incurred $4,000 of covered charges, during a calendar year, which are payable at 80%, Major Medical pays 100% of covered charges (other than those for (1) mental and nervous conditions and (2) dental conditions) subsequently incurred within that calendar year which are not required to satisfy a deductible.

Benefit Period

A benefit period is established and benefit payments begin when you have, or your dependent has, incurred during a calendar year, eligible charges for all illnesses which exceed the deductible amount. All eligible charges for all illnesses incurred during a benefit period are used in computing benefit payments.

A benefit period terminates on the last day of the calendar year in which it was established.

Maximum Benefit

The maximum benefit is a lifetime aggregate for all illnesses. However, a person who has received payment for all or a part of the maximum benefit, will have up to $2,500 of his maximum automatically reinstated each January 1st. The full maximum benefit may be reinstated upon approval of evidence of insurability satisfactory to The Lincoln.

If at any time, while covered under this plan, a person's Major Medical Expense Benefit maximum benefit is increased, such increased maximum benefit shall not apply to any charges incurred in connection with a bodily disorder or disease, a mental infirmity or bodily injury contracted prior to the date the Major Medical Expense Benefit maximum benefit increased, unless such charges are incurred after a period of

three consecutive months or longer, ending after such date of increase, during which no care or treatment is received in connection with such injury or illness.

Family Injuries - Single Accident

If more than one member of a family unit is injured in a single accident, a single deductible amount will apply for benefit periods commencing as a result of the accident.

-- THE FOLLOWING CHARGES (IF NECESSARY, REGULAR AND CUSTOMARY) ARE COVERED MAJOR MEDICAL EXPENSES --

Board and room and routine nursing service for confinement in a hospital, limited to the hospital's prevailing charge for a semi-private room;

Charges by a hospital for medical services and supplies;

Anesthetics and the administration thereof;

Fees of legally qualified physicians or surgeons for medical care or treatment (personally rendered in the physical presence of the patient),

Fees of legally qualified physicians or surgeons for surgical operations;

Fees of graduate registered nurses (R.N.) for private duty nursing services, fees of licensed practical nurses for private duty nursing services rendered in a hospital to a registered bed patient, and fees for treatment by a licensed physiotherapist, other than a nurse or physiotherapist who ordinarily resides in the same household with you, or who is related by blood, marriage, or legal adoption to you or your spouse;

Fees for: (1) x-ray examinations, (2) microscopic and laboratory tests, (3) diagnostic services, (4) x-ray or radioactive therapy, but NOT dental fees;

Charges by a legally qualified physician or qualified speech therapist for restoratory or rehabilatory speech therapy for speech loss or impairment due to an illness, other than a functional nervous disorder, or to surgery on account of an illness. If the speech loss or impairment is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy;

Charges for necessary transportation (within the continental U.S.A. and Canada) of the patient by professional ambulance services, or railroad, or regularly scheduled airline, to, but not returning from, a hospital or sanitarium equipped to furnish treatment for the illness,

Medical supplies prescribed by a legally qualified physician or surgeon, as follows: drugs and medicines which require a written prescription of a physician and which must be dispensed by a licensed pharmacist or physician, blood and other fluids to be injected into the circulatory system, artificial limbs and eyes, casts, splints, trusses, braces, crutches and surgical dressings, rental of hospital-type equipment, including wheel chair, hospital bed, iron lung, and other mechanical equipment for the treatment of respiratory paralysis and equipment for the administration of oxygen;

Charges incurred for Board and Room and routine nursing services for confinement in a Skilled Nursing Facility up to the semi-private rate charged by the facility, provided the confinement commences within fourteen days following confinement in a hospital for at least three consecutive days for the same illness and provided also that the confinement is not for routine custodial care and that the patient is personally visited at least once each thirty days by his physician.

"Skilled Nursing Facility" means an institution which is approved as such for Medicare.

-- THE FOLLOWING CHARGES ARE NOT COVERED --

- All Charges Not Specifically Listed As Covered Charges And In Addition -

Charges for eye refractions, or the purchase or fitting of hearing aids or eye-glasses;

Charges for, (a) the care, treatment or operation on the teeth, gums or alveolar process, (b) dentures, appliances or supplies used in such care and treatment, unless such expenses are incurred as a resu t of an accident, which occurred while insured. Then charges for treatment of injuries to natural teeth, including replacement of such teeth, or for setting of a jaw, fractured or dislocated in the accident are covered, if the charges are incurred while insured and within twenty-four months of the accident;

Charges for, or in connection with, care, treatment or operations, which are performed for cosmetic purposes, unless such expenses are incurred as a result of an accident which occurred while insured;

Charges which you are not legally obligated to pay, such as for U.S. Government Hospital confinement and services, and charges payable as Worker's Compensation claims; except this exclusion does not apply to services rendered for a nonoccupational illness in a nongovernmental charitable research hospital, as defined in the Master Policy,

Charges for care or treatment as a result of war, declared or undeclared;

Mental Illness

Charges for professional services in connection with mental illness(es) or functional nervous disorder(s) of any type or cause or for psychiatric or psychoanalytic care for any reason are not covered except those for services rendered by a legally qualified physician during a visit by or to the patient and which are not in excess of (a) a payment of $20 for each visit, (b) one visit on any one day, or (c) 50 visits during any calendar year. (The word "VISIT" includes each attendance of the physician to the patient, regardless of the type of professional services rendered, whether it might be otherwise termed consultation, treatment, or described in some other manner).

HOME HEALTH CARE EXPENSE INSURANCE

Home Health Care Expense benefits provide payment of 80% for eligible home health care charges up to the maximum payment for a single visit shown in the Schedule of Benefits. These benefits are payable up to a maximum of 100 visits during any one calendar year.

-- THE FOLLOWING HOME HEALTH CARE CHARGES
(IF NECESSARY, REGULAR AND CUSTOMARY) ARE COVERED --

Charges for any accidental bodily injury: (a) which does not arise out of or in the course of any employment by the Employer and (b) for which he is not entitled to benefits under any Workmen's Compensation law;

Charges for any sickness not entitling him to benefits under any Workmen's Compensation or Occupational Disease law;

Provided such charges,

1 are medically necessary for the treatment of an insured individual who is totally disabled and who, in the opinion of the attending physician, would otherwise have been confined as a registered bed patient in a hospital or skilled nursing facility provided:

   a. the insured individual is under the direct care of a legally qualified physician,

   b. the plan of treatment covering the Home Health Care s established in writing by the attending physician prior to commencement of such treatment,

   c. the plan of treatment covering Home Health Care s certified by the attending physician at least once every month, and

   d. the insured individual is examined by the attending physician once every 60 days.

2 are for charges which are provided by a home health agency which is an agency or organization meeting the following requirements:

   a it is primarily engaged in and is federally certified as a Home Health Agency and is duly licensed by the California State Department of Health Services to provide nursing and other therapeutic services (as listed in 3. below),

   b its professional service policies are established by a professional group associated with such agency or organization, including at least one legally qualified physician and at least one registered nurse (R.N.), to govern the services provided,

   c it provides for full-time supervision of such services by a legally qualified physician or by a registered nurse (R.N.),

   d. it maintains a complete medical record of each patient, and

   e. it has an administrator.

3 are for charges which are incurred for one or more of the following, unless such charges are eligible charges under Major Medical Expense Insurance:

   a. part-time or intermittent nursing care, by a licensed vocational nurse (L.V.N.),

b. part-time or intermittent Home Health Aide services,

c. occupational therapy, provided such therapy is performed by a licensed therapist if licensing is required by the state in which the therapy is performed,

d. social work, performed by a licensed social worker if licensing is required by the state in which the social work is performed (if licensing is not required by the state the social worker must have at least a Masters degree in social work with one or more years of clinical social work experience),

e. nutrition services performed by a licensed nutritionist, if licensing is required by the state in which the nutrition services are performed, and

f. special meals.

4. are not excluded charges and are not otherwise excluded from coverage by the terms hereof.

-- THE FOLLOWING HOME HEALTH CARE CHARGES ARE NOT COVERED --

- All Charges Not Specifically Listed As Covered Charges And In Addition -

Charges for services for which the individual is not, in the absence of this insurance, legally required to pay;

Charges for services performed by the insured's immediate family or any person residing with the insured;

Charges for general housekeeping services, or;

Charges for services for custodial care.

PRE-EXISTING CONDITIONS

Except for an initial payment up to $1,000, charges for the care and treatment of illness existing on the date of coverage are not covered until at least:

(a) a three months' period of time occurs, ending after such effective date, during which period the person has not received any care or treatment in connection with such injury or illness, or

(b) a period of twelve months or longer, during which the person was continuously insured.

CO-ORDINATION OF BENEFITS

If a person is eligible for medical or dental benefits under any other plan of coverage:

(a) for individuals in a group, whether on an insured or uninsured basis (such as group insurance and student insurance);

(b) provided under any governmental program; or

(c) required or provided by any law,

the benefits of This Plan may be reduced so that during the calendar year up to, but not more than, 100% of the person's medical or dental expenses (at least a portion of which is covered under one or more of such Plans) will be paid by all such Plans.

MEDICARE SUPPLEMENTAL EXPENSE INSURANCE

For those employees or dependents who are covered or eligible to be covered for Medicare, benefits will be paid under this Group Insurance Plan to the extent of the difference between the dollar amount stipulated under both Parts A and B of Medicare and the dollar amount of benefits that would have been paid under this Group Insurance Plan if the individual had not become eligible for Medicare.

ELIGIBILITY & GENERAL INFORMATION

ELIGIBILITY

If you are a full-time employee actively at work, you are insured from the inception of the plan New full-time employees are insured from the day following one month of continuous active service.

If you do not work an average of at least 30 hours per week you are not eligible.

If you are not actively at work on the Certificate Effective Date, you are not insured until the next following day on which you are actively at work.

If you are not actively at work on the date the amount of your insurance would otherwise be increased, such increase is not effective until the next following day on which you are actively at work.

If your dependent is confined in a hospital on the date you would otherw se become Insured for dependent's insurance (or your insurance would be increased with respect to this dependent) such insurance Is not effective until the day following this dependent's final discharge from the hospital. However, a live born baby is eligible from birth whether hospital confined or not, except for charges for regular and customary services normally furnished a well baby.

Dependents include your spouse and unmarried children from the dale of live birth until 19 years (23 years if a full-time student in an accredited school) except that this maximum age limit does not apply to a ch ld who is mentally or physically incapable of earning a living on the dale the child attains this maximum age as long as such incapacity continues, if initial due proof of such incapacity is received by The Lincoln within 31 days of the date the child attains such maximum age and if due proof of the continuance of such incapacity is furnished The Lincoln as it may reasonably require. Stepchildren and legally adopted children are eligible dependents, but parents or other relatives, are not eligible for dependent coverage even though supported by you.

During any period that a husband and wife are both concurrently insured as employees herein, (1) each will also be deemed a dependent of the other and (2) each dependent child of such husband and wife will be deemed a dependent of both husband and wife, and for the purposes of Co-Ordination of Benefits, such spouse or child will be deemed to be insured under a different Plan of Insurance as outlined under Co-Ordination of Benefits.

GENERAL INFORMATION

You need lo complele an individual enrollment card. If you do not enroll your dependents within 31 days after becoming eligible, satisfactory evidence of insurability is required for each dependent

Benefits for loss of your life are payable to the beneficiary designated by you. All other benefits are payable to you If you have named more than one beneficiary, and not designated the share for each, the

benefits will be paid equally, or to the survivor. If you have named no beneficiary, payment will be made to your estate or at The Lincoln's option, to your widow or widower, if living, otherwise, to your living children, if any, otherwise, to your parents, if living. If you die before The Lincoln makes payment on disability benefits, payment will be made to your beneficiary, or, at The Lincoln's option, to your estate.

You have 20 days from the date of commencement of the first loss for which benefits are claimed to give The Lincoln (through your employer) written notice of injury or sickness upon which you base your claim.

Following notice of death, injury, or sickness, a claim form will be furnished for filing proof of claim. If The Lincoln does not furnish the form within 15 days of the notice to its Home Office, the terms of the policy will have been complied with by submitting written proof covering the occurrence, character and extent of the loss for which claim is made.

You have 90 days after the date of loss to furnish proof of claim to The Lincoln.

If you do not furnish notice or proof within the time allowed, your claim will still be considered if you show that it was not reasonably possible to furnish the notice or proof and that the notice or proof was furnished as soon as was reasonably possible.

Any benefits provided in the Policy will be paid immediately after receipt of proof of claim.

The Lincoln reserves the right and opportunity to examine the person whose injury or sickness is the basis of claim as often as it may reasonably require during the duration of the claim.

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of claim has been filed, nor shall action be brought at all unless brought within 3 years from the expiration of the time within which proof of claim is required by the policy.

The Lincoln reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to you and any assignees.

This insurance is not in lieu of and does not affect any requirements for coverage by Worker's Compensation insurance.

This supersedes and replaces certificates, if any, previously issued to you.

Termination of Benefits

Your insurance will automatically terminate on the earliest of the following dates: when termination of employment occurs, the last day for which your premium has been paid, the date the Master Policy terminates.

If you are unable to work because of disability, on leave of absence or temporary lay-off, or retired, inquire of your employer as to your rights, if any, under the Master Policy.

NOTICE - If your insurance terminates because you cease active work as the result of a labor dispute, inquire of the trustees, your union or the Policyholder, whichever is applicable, as to your rights under the Master Policy. Arrangements may be made to continue your insurance in effect under the group policy for no longer than six months if certain conditions of the group policy are met, including payment of the required premium by at least 75% of the employees. Your insurance has terminated unless such arrangements are made within the time allowed.

The insurance for a dependent automatically terminates on the earliest of the following dates: (a) the date coverage for dependents is terminated under the Master Policy, (b) the date your insurance terminates, (c) the last day for which your dependent's premium has been paid, (d) the date your dependent child becomes personally insured under the policy, (e) your spouse on the date of your divorce or legal separation, (f) your child, on the child's 19th birthday (23rd birthday if a full-time student in an accredited school) except that this maximum age limit does not apply to a child who is mentally or physically incapable of earning a living on the date the child attains this maximum age as long as such incapacity continues, if initial due proof of such incapacity is received by The Lincoln within 31 days of the date the child attains such maximum age and if due proof of the continuance of such incapacity is furnished The Lincoln as it may reasonably require, or the date of the child's marriage, whichever is earlier.

Conversion to Regular Hospital and Surgical Insurance

Within 31 days from the date of termination (provided the employer's Master Policy has not terminated), except for those persons eligible for Medicare, you may convert, for yourself and your dependents, to regular hospital and surgical coverage. This conversion privilege is also available to your spouse upon dissolution of marriage. For complete information, secure Conversion Form from your employer. (Refer to the first subject in this brochure, "Life Insurance", for conversion of that benefit).

PLAN ARRANGED BY:

Robert D. Clark, CLU
1570 The Alameda, Suite 327
San Jose, California 95126

(408) 295-6408

The Lincoln National Life Insurance Company
Fort Wayne, Indiana 46801

PTT GROUP INSURANCE PLAN

(Corporate Employees)

Date of Origin: 1982
Archived: 5-21-12
Submission by Tristan R.
Version 1.0

The documents contained herein are for educational use only. Please do not replicate, redistribute, or make any unauthorized printings. All intellectual property including characters, artwork, photography, and slogans are trademark and/or copyright their respective owners.